REQUEST FOR MEDICAL EVALUATION

Please FAX to 617-351-9223 and mail original to:
Medical Affairs, P.O. Box 55889, Boston, MA 02205

This form is used to report a person you believe is no longer physically or medically capable of operating a motor vehicle safely. Pease provide as much information as possible.

Information about the Driver: (required)

Last Name: _____ First Name: _____

License or Social Security Number: _____ Date of Birth: _____/_____/_____

Current Address: _____

_____

Please briefly describe reason for concern: _____

_____

_____

By signing this form, I certify to the best of my knowledge and under the pains and penalties of perjury that the above information is true:

Signed: _____ Date: _____/_____/_____

Name: _____ Phone: _____
(please print)

FOR LAW ENFORCEMENT or MEDICAL DOCTORS ONLY

(If not law enforcement or a medical doctor, please leave this section blank.)

Please check <u>one</u> of the following categories:

I hereby certify that in my professional opinion and to a reasonable degree of certainty,

- ☐ The person named above is NOT medically qualified to operate a motor vehicle safely.
- ☐ I am unable to determine driving ability and I recommend the person undergo a competency road examination.
- ☐ The person may require adaptive equipment and/or an assessment for appropriate license restrictions via a competency road examination.

Please complete applicable areas:

Signature: _____ Date: ____/____/_____

Name: _____ Phone: _____
(please print)

Profession / Title: _____
(e.g., Law Enforcement/ Lieutenant *or* Medical/ Doctor)

Place of Employment: _____
(e.g., Saugus Police Dept. *or* Boston Medical Center)

Medical Professionals, please provide Board of Registration Number: _____

Law Enforcement Professionals:

Was the driver cited by you? ☐ No ☐ Yes, Citation Number: _____